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Letter dated 15 June 2009 from the Permanent Representative of Sri Lanka to the United Nations addressed to the President of the Economic and Social Council

I have the honour to transmit herewith the national report of the Democratic Socialist Republic of Sri Lanka, entitled "National Development Strategies and Commitments to Achieve the internationally agreed development goals, including the Millennium Development Goals: Sri Lanka National Report", for the annual ministerial review to be held during the high-level segment of the 2009 substantive session of the Economic and Social Council (see annex).

I would be grateful if you would kindly circulate the present letter and its annex as a document of the Council, under item 2 (b) of the provisional agenda.

(*Signed*) H. M. G. S. **Palihakkara**
Ambassador
Permanent Representative

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Annex to the letter dated 15 June 2009 from the Permanent Representative of Sri Lanka addressed to the President of the Economic and Social Council

National Development Strategies and Commitments to Achieve the internationally agreed development goals, including the Millennium Development Goals: Sri Lanka National Report

Executive summary

Development policy in post-colonial Sri Lanka has had certain unique features. As articulated, policy was to be guided by a set of multiple goals, including economic growth, redistributive justice, poverty alleviation, employment promotion, balanced regional development and environmental sustainability. The implementation of this policy framework, however, encountered significant problem as it constantly required sorting out difficult and complex trade-offs, contradictions and challenges. Yet Sri Lanka was able to achieve within this policy framework a series of human development outcomes which are widely acknowledged as desirable.

Between the times of the first and the final drafts of this National Voluntary Presentation (NVP), Sri Lanka has experienced the gradual unfolding of a momentous historical process, namely the gradual decimation of the Liberation Tigers of Tamil Elam (LTTE) which, for nearly three decades, led a destructive separatist-terrorist movement in the country. The elimination of this movement in May 2009 augurs well for democratic values and processes, which Sri Lanka tried to uphold throughout its post-colonial history. Furthermore, the complete transformation of the security situation has opened up enormously bright prospects for the country to go for accelerated socio-economic as well as political development, building on what has already been achieved.

Sri Lanka has already attained or on track to attain the MDGs related to poverty, education and health, subject however, to significant regional disparities. Relatively promising economic performance – e.g. over 5 percent growth since 2002 and the decline in unemployment to 5 percent – has helped. Sri Lankan socio-economic policy continues to be market driven but with a new focus on promoting domestic / indigenous economic activities. In addition, several measures are being taken since 2005 to distribute the benefits of growth more equitably. The poverty decline process has therefore gained momentum. The improvement of the security situation enables the policy makers now to focus systematically on improving living conditions of people in the north and the east. The urban-bias widely observed under neo-liberal policies is likely to be moderated by recent policy prioritization of agricultural and rural development. National revival since the triumph over separatist-terrorist forces is likely to be used as a positive force to accelerate "economic growth". The traditional "welfare state" model – income transfer schemes, free education and healthcare

services and so on – that is familiar to Sri Lanka is to be retained. It is this policy background which produced the outlier status in inter-country comparisons, which Sri Lanka is known for.

It is accepted that the primary responsibility of moving towards IADGs rests with the government. Yet ODA flows and other forms of foreign assistance have made a significant contribution to Sri Lankan development. With Sri Lanka crossing the middle income country threshold in the late 1990s ODA flows gradually declined. For required foreign resources for developmental purposes, the government has turned in recent years increasingly towards concessional loans from non-DAC countries and for commercial borrowing.

A few main points have been raised in this NPV about issues and challenges faced by Sri Lanka in its move toward IADGs. First, aggregative achievements in all areas of human development are subject to variations across social groups and regionally. Second, subsidized facilities and services provided, heavily dependent as they are on the government budget, are subject to uncertainties of long term financial sustainability. They are criticized also for not being targeted. Third, the heavy concentration of unemployment among the youth and the educated continues though the overall rate has declined. Furthermore, a gradual improvement in the structure of available occupations is needed, increasing the availability higher quality occupations. The quality issue comes up in other spheres like education and health services as well. Fourth, making modern science and technology (S&T) available to distant and rural communities is of vital significance to ensure equitable development. Policy action taken to disseminate S&T to distant rural areas has been noted positively. Fifth, Sri Lankan policy highlights the significance of environmental sustainability in all developmental activities but measures introduced to promote environmental sustainability are subject to huge implementation challenges. Sixth, and most important, the issues concerning national integration are perhaps the most challenging in the time to come. Of particular significance would be those pertaining to relations between the ethnic Sinhalese and the ethnic Tamil communities. Policy statements since the defeat of the LTTE and action taken on the ground to address the issues concerned make one optimistic about what the future holds.

Part B of this NVP covers performance of and challenges faced by the healthcare sector in Sri Lanka. Principal health policy approaches, human and physical facilities in the public healthcare sector, its contribution to the country's human development achievements and issues and challenges faced are some of the subject areas investigated. The healthcare sector has expanded over time thanks largely to resources pumped in by the state. As the return to the large annual flow of public funds into the health sector people's health conditions have improved significantly. A series of socio-economic and political factors contributed to the low income Sri Lanka's "success story" of improving people's health. Among these, the contribution of the healthcare sector has been substantial.

There are two salient features of the system of management of Sri Lanka's public sector healthcare system: (i) the provision of healthcare free of charge and (ii) provision of services close to the client. A private sector in healthcare provision has also been allowed to grow. Public sector healthcare authorities play the lead role in promotional, preventive, curative and rehabilitative services. The public sector supports a pluralistic system of healthcare, with a policy commitment to promote indigenous systems of medicine like the ayurvedic tradition.

The healthcare sector has been active in spheres of preventive and curative care. The incidence of communicable and parasitic diseases was brought down substantially. The immunization program in Sri Lanka has already achieved virtually total coverage. These plus the process of general socio-economic development were able to raise national health indicators to impressive levels. Curative care facilities within public sector medical institutions have also been substantially upgraded through organizational reforms and higher investments. Action is being taken to address issues of equity in the regional distribution of healthcare facilities. Medical technology that is available in major hospitals has been upgraded. Employment numbers and medical supplies in government healthcare institutions have been expanded, thus helping in the process of improvement in the quality of services provided.

In the midst of commendable achievements, the healthcare system of Sri Lanka currently operates under many challenges and stresses. These challenges are mostly systemic and institutional, associated with the overall country situation in terms of macro-economic, developmental, historical, social, political and legal considerations. The NVP briefly discusses the following challenges: (i) epidemiological transition of a shifting burden of ill health from communicable and parasitic to non-communicable diseases; (ii) financial resource constraints due to heavy dependence on resources raised from taxation with little help coming from user fees; (iii) problems related to the system of devolution of powers under the Provincial Council system; (iv) human resource constraints; (v) administrative / managerial issues of running the complex, huge and centralized healthcare system; and (vi) problems of ensuring equity in healthcare provision.

This sector study is instructive about how the government of a country could help achieve valuable social goals through systematic intervention, in spite of the level of economic attainment being not very helpful in the process. Sri Lanka shows how a developing country could attain high levels of healthcare goals, even in the absence of comprehensive health insurance schemes, by setting aside a small share of government tax revenues for public healthcare expenditures. What the rest of the world can learn from Sri Lankan healthcare sector experience is immense.

I. Introduction

The internationally agreed development goals (IADGs) as articulated by the international community incorporate the widely publicized Millennium Development Goals (MDGs) and a few others. As summarized in a recent UN document, IADGs extending beyond MDGs cover systemic issues and commitments of a political and socio-cultural nature – goals of good governance, democracy and human rights including the rule of law, minority rights and free media, social integration, protection of vulnerable groups, respect for cultural and racial diversity and respect for human rights of migrants (UN, 2008). A process of Annual Ministerial Reviews (AMR) of achievement of these goals at individual country level has been initiated at the United Nations level. The year 2009 is the third year of such AMRs. National Voluntary Presentations (NVP) are prepared to provide the framework for these evaluations.

This study is the NVP of Sri Lanka. It has been prepared in a participatory manner. The first draft was written on the basis of discussions with members of an official steering committee. After a round of revisions on the basis of comments received from some of the stakeholder Ministries, it was subjected to extensive discussion in a national workshop in which a representative group of stakeholders from concerned ministries and departments, the academia, international agencies, domestic civil society and the private sector participated and provided their inputs. The present draft of the report accommodates the significant opinions and views expressed in this national workshop.

The objective of this NVP is to examine and provide an assessment of how Sri Lanka has implemented its national development strategies to achieve the IADGs. This presentation, it is hoped, will enable the development community to understand Sri Lanka's policies and circumstances so that they could, on the one hand, provide some feedback to enable Sri Lanka to improve its own performance and on the other hand, share lessons learned so that effective good policies and good practices can be replicated elsewhere.

The study is prepared in two main parts. Part A has three main sections (II, III and IV) meant to achieve two broad analytical objectives. First, the overall development policy in Sri Lanka is examined and analyzed in Sections II and III. Second, a critical review is made of Sri Lanka's performance and challenges it faced in the achievement of IADGs, with special focus on MDGs (Section IV). There are already several comprehensive studies to cover Sri Lanka's achievements in MDGs [World Bank (2005); NCED & UNDP (2005); NCED & UNDP, (2009); DCS (2009)]. The presentation in section IV is therefore, tightly compressed and summarized. Part B of the report presents a focused study of historical development, policies, institutional structures, achievements and challenges in the country's healthcare sector. The role of

this sector in enabling Sri Lanka to achieve its widely acknowledged IADG gains has been of enormous significance.

The comprehensive data base that is available in Sri Lanka has been a great asset in preparing this NVP. This data base has been gradually built up over the years through statistical surveys and administrative processes. The focused analytical work carried out more recently to monitor MDG achievements must also be mentioned here. Some problems in regard to available data must however, be noted. The absence of reliable information for the northern and eastern provinces of the country was due to conditions of conflict and violence there during the last several decades. With the return of peace to these regions in mid-2009, the authorities are optimistic of being able to produce more reliable sets of information covering the entire country from this year onwards. Another problem related to statistical information on topics covered in this report is that several official agencies – e.g. Department of Census and Statistics, Central Bank, Ministries of Healthcare, Education and Environment, to name only a few – do publish data on apparently the same subject but with some mutual incongruence. Discrepancies are usually insignificant and no attempt has been made in this study to examine this data discrepancy issues in any depth.

Part A: Socio-Economic Policy and MDGs

II. Social and Economic Policy in Sri Lanka

Those who review Sri Lanka's development record since de-colonization often raise two important points. First, production forces in Sri Lanka have expanded during this period, but relatively slowly in comparison with, for example, the high growth countries of East and Southeast Asia. As a result, most of the latter were able gradually to reach higher income positions than Sri Lanka although, at the end of World War II, they occupied lower income positions. Second, in terms of social indicators and other measures of human development, Sri Lanka has done better than in terms of GNP per capita thanks largely to human development friendly socio-economic policy in the country.

The process of political /constitutional experimentation during the two closing decades of the British colonial rule in Sri Lanka, particularly the introduction of partial self-rule based on universal adult franchise in 1931, led to the gradual development of a nascent version of a "welfare state" in the country (Wickramaratne, 1973; Alailima, 1997; Jayasuriya, 2000). The early Sri Lankan welfare state was characterized by (i) universalistic application, subject to no targeting of benefits, (ii) an income redistributive rationale, (iii) no schemes of institutionalized social security and income maintenance and (iv) a pronounced urban bias in the delivery of services and benefits, compensated by a package of rural development policies (Jayasuriya, 2000). For funding it depended on the financial surplus appropriated by the state from the

country's export crop sector. The impact of these early policy innovations, whatever their limitations, was to make Sri Lanka develop into what has been described as an "outlier" position in inter-country comparisons of income levels and "social indicators" (Isenman, 1975). And today the Happy Planet Index (HPI) – an index of human well-being and environmental impact – introduced by the New Economics Foundation (NEF) in 2006, ranks Sri Lanka 15th out of 178 countries[1].

This welfare state system was part of the holistic concept of development pursued by many post-independence Sri Lankan governments. The components identified in this holistic version of development were economic growth, redistributive or social justice and employment creation. New elements like poverty alleviation and environmental sustainability were added to the cluster of accepted policy goals as changing perceptions of international good practice so demanded. Trade-offs and sacrifices involved when trying to achieve these goals simultaneously were admitted (Lakshman, 1975). This commitment to a holistic vision of development continued in spite of changes of governments, subject however, to changes in the relative weights placed on different elements in the multi-dimensional perception of development.

The most far reaching change of socio-economic policy since independence occurred in the late-1970s. Beginning in 1977, the country commenced a transformation from the state-dominant "control regime" of the time to a liberalized market economy open to the on-going globalization process. Policies of liberalization and globalization have had the reputation almost everywhere in the world for their over-enthusiasm for economic growth. Policy emphasis in Sri Lanka too was similarly biased. The cutbacks on government social sector expenditures in the 1980s are well documented (Alailima, 1997: 157). The new approach to welfare under policies of liberalization was marked by (i) a significant reduction of social expenditure, (ii) a selectivist approach with an element of targeting, (iii) de-prioritization of redistributive justice objectives, (iv) encouragement of commercially delivered social services and (v) the increased emphasis on rural sector modernization (Jayasuriya, 2000).

The current phase in Sri Lankan socio-economic policy continues to be market driven but with certain important strategic changes. The state is taking up a stronger regulatory and promotional role. This phase in policy evolution began in 2005 with the election of a new Executive President on an election manifesto with a difference (Rajapaksa, 2005). The main themes in this election manifesto were later detailed out by the Department of National Planning in the Ministry of Finance into a ten year development policy framework (Department of National Planning, 2006). The new

[1] Policy choices which facilitated the achievement of these superior human development outcomes have been viewed negatively as well. One such point of view was that due to these policies the Sri Lankans "learnt to enjoy the fruit before planting the tree". Sri Lankan human development achievements were also called "support-led" (implying non-sustainability) rather than "growth-mediated" (and therefore being sustainable). Another similar comment was that Sri Lankan policy was one of "sharing poverty".

policy approach according to this document is to integrate "... the positive attributes of market economic policies with domestic aspirations, by providing necessary support to domestic enterprises and encouraging foreign investment" (p. v). The policy objective has been presented as that of improving growth prospects with equitable development in the country, with special emphasis on the needs of lagging regions.

Overall, Sri Lankan policy goals could thus be seen as pro-IADG and pro-MDG by their very nature. Sri Lankans have effectively used the complementarities among education, gender equity and good health to bolster its IADG achievements. The effective achievement of a system of multiple goals however, has been extremely difficult as it constantly required sorting out difficult and complex trade offs, contradictions and challenges.

III. The Framework of Policy Measures

This study is predominantly about human development achievements of Sri Lanka. Human development emanates from growth of production, productivity and employment and the manner of distribution of what is produced. All production and distribution processes are directly or indirectly, and to a large or small extent, influenced by government policy. The following sub-sections attempt to trace the main elements of socio-economic policy in Sri Lanka, which influenced one way or the other, the extent of its achievement of IADGs/ MDGs. Let us take, for example, the poverty alleviation aspect of human development. It is a function of a wide variety of socio-economic developments, whether they take place independently of or in response to policy action introduced with the intention of directly impacting on social groups in poverty. The analysis of IADG/MDG promotional measures would, on this kind of reasoning, turn out to be an analysis of the entire gamut of development policy measures. This study does not have so extensive a coverage. In the next sub-section some reference is made to important elements of overall economic policy measures of the last three decades in Sri Lanka. Subject coverage in subsequent sections is restricted within feasible limits and only policy measures with a particular "human" development bias have been taken up for review.

III.1 Overall Policy Approach

Sri Lanka has been among pioneers in the recent global trend towards market-oriented policy within the framework of liberalization, deregulation, privatization and globalization. The process of policy reform has commenced in 1977. During much of the period 1977-2005, economic policy was guided by the World Bank and the IMF, within a "structural adjustment" type macro-policy model. In more recent times, regionalism has been pursued in trade matters. Regional trading arrangements have been viewed as a springboard for broader trade liberalization. Policies of promoting foreign direct investments (FDI), export-oriented production, technology transfers

from advanced countries and relatively free foreign exchange transactions in the current account of the balance of payments have formed other major components of Sri Lanka's liberal economic policy package. In addition, until Sri Lanka crossed the "middle-income country" threshold recently, many bilateral and multilateral donor agencies have considered Sri Lanka as a priority recipient of Overseas Development Assistance (ODA).

In more recent times, concerns have come to be expressed about the effects of policies of liberalization and globalization on domestic/ indigenous production sectors. Economic policy after 2005 reflects an attempt to be independent of the structural adjustment model, without completely abandoning relative "openness" to foreign trade and FDI (Rajapaksa, 2005). Special promotional treatment is, however, given to domestic economic activities, including those of the import substitution type. An attempt is being made to manage imports in such a way as to protect and promote such domestic production activities. Announcement has been made that there would be no privatization of state owned enterprises.

Sri Lankan policy, whatever political party was in power, indicates a clear commitment to democratic values. Democracy, human rights and good governance are valued policy goals. Every elected government would claim adherence to these democratic values while the political opposition would be highly critical of incumbent government's record in democratic practice. Violent conflict has not been very helpful in maintaining practices of good democratic governance and safeguarding of human rights. With the termination of the conflict between the LTTE and the Sri Lankan state in mid 2009, there are now strong prospects for the implementation of a suitable package of social, political and economic solutions to address the underlying causes of this protracted conflict. These conditions augur well for strengthened democratic practice in the time to come.

III.2 Poverty Focused Measures

Welfare programs aimed at reducing poverty, hunger and morbidity have been common in Sri Lanka. These included the food subsidy scheme (1942-77), food stamp scheme (1979-89), Janasaviya program (1989-94), and finally Samurdhi program (1995 to date) together with the widely publicized "free" education and healthcare services. The Samurdhi program, which is currently the principal poverty reduction program of the government, adopts short-term as well as long-term strategies – income transfer and livelihood support, social insurance and social development via empowerment and mobilization of people – to achieve its objectives. In addition, there are several rural development projects by names like 'Gama Naguma', 'Maga Neguma', 'Gemi Diriya' and 'Jana Pubuduwa'. Projects to carry modern information technology facilities to rural areas are also implemented. In addition, several extensive projects are being implemented for alleviation of poverty among those in the estate sector through improvement of the conditions of working class houses in estates,

development of water and sanitation facilities, provision of electricity for estate houses, job-oriented training for the unemployed youth in estates and so on. Promotion of livelihoods among the poor via both wage employment and self employment is an important element in many poverty reduction projects and programs. All these interventional measures for poverty reduction have had a significant salutary impact on incidence of poverty and hunger, particularly in rural Sri Lanka, including the estate sector, comprising the bulk of the poor population in the country.

III.3 Social Sector Measures – Education and Health

Education in Sri Lanka has had important crosscutting impacts on all desired aggregative human development goals, namely economic growth, distributive justice, poverty alleviation and so on. Broadening of educational opportunities and improvement of national education systems have received utmost importance and high priority. Sri Lanka's children and youth, both male and female, have enjoyed free education from kindergarten to the University level, since the Education Act of 1945. The Education Act of 1998 has made education compulsory for all children aged 5 to 14 years. These legislative changes and other institutional measures have made educational facilities more inclusive in coverage. There are real issues of regional inequality in educational facilities and quality variation from one educational institution to another. Nevertheless, over 9,700 public sector schools falling into four different categories, with over 3.8 million pupils and 204,000 teachers, together with a large number of non-governmental educational institutions[2], some receiving government support and others completely on their own, provide a well spread institutional infrastructure to educate the society. A general principle in Sri Lankan educational policy since the 1940s has been gender equality in facilities provided. Educational welfare programs to provide free school text books, free mid-day meals, free school uniform materials, and subsidized transport facilities (bus and/or train) for students, are some measures rendering free education more meaningful. Various scholarship schemes like the one at grade 5 level open up educational facilities for the promising children from all social classes. In order to make educational facilities more inclusive a number of programs are currently being operated to assist children from selected vulnerable groups in society – e.g. the plantation communities, people in the areas formerly affected by civil war conditions and the "aboriginal" *vedda* community. Special programs are available to educate children with disabilities, street children, the displaced and those in IDP camps and in detention. Policy action to reduce the

[2] 40 non-fee levying private schools, 29 fee-levying private schools, 24 special schools, 653 educational institutions called pirivenas which cater mostly but not exclusively to educational needs of the Buddhist clergy, and 461 non-formal education centres. These are institutions having their links with the Central Government Ministry of Education and there are also a large number of fee-levying schools, often called "international" schools and registered with the Board of Investment. The bulk of pupils in these "international" schools are, however, local.

incidence of child labour helps in these moves toward achieving universality of education.

Healthcare sector is examined in detail in Part B of this NVP and only a few general points are made about it at this stage. Sri Lanka has made significant improvements in its health services during the recent past, while remaining within the fundamental policy premise of providing healthcare services within the public sector free of charge to all who care to use these services. Within this free healthcare system, measures have been taken to immunize children, to reduce malnourishment among them, and to educate pregnant women and mothers. A maternal and child care program is being implemented nationally. Health authorities have successfully implemented many preventive campaigns against communicable and parasitic diseases. High literacy rate among people and certain aspects of the local culture have helped authorities to achieve a high rate of success in these programs. Establishment and improvement of sanitation facilities in urban and rural areas, maintenance and upliftment of systems of rainwater drainage and solid waste disposal in urban settings have helped in promoting healthy life.

III.4 Environmental Sustainability

The government of Sri Lanka has taken a number of positive steps to ensure environmental sustainability. The National Environmental Act was enacted in 1980. The Central Environmental Authority (CEA) was established in 1981 and a cabinet rank Ministry for Environment in 1990. The national environment policy makes it the duty of every citizen to "protect nature and conserve its riches". It lays down the objectives and principles of environmental management. Forest cover issues and those of biological diversity are taken up for regulatory action, with a National Forest Policy, a Forest Sector Master Plan and a Biodiversity Conservation Action Plan formulated in the 1990s. A National Wildlife Policy was formulated in 2000. Issues pertaining to the energy sector, carbon dioxide emissions and consumption of CFCs as well as water and sanitation are high on the policy agenda. Being a signatory to international agreements pertaining to climate change Sri Lanka is engaged in building up the institutional machinery needed to implement the commitments. Action has been initiated in subject areas of solid waste management, "greening" of cities, minimization of human-elephant conflicts in affected areas and promotion of bio-fuels, solar power use and rain water conservation. The strong policy attention to environmental sustainability is explained by the vision of "a land that is in harmony with nature", which guides policy action.

IV. Accomplishments and Challenges

This section examines Sri Lanka's achievements in its move towards IADGs and challenges encountered in further progress in that direction. Progress achieved in terms

of human development indicators has been significant in an overall or average sense. In respect of almost every such indicator however, there is a problem related to the pattern of spread, across and within social groups as well as regionally. While average general conditions are satisfactory, certain segments in society have to go a long way to attain conditions corresponding to the average. Inter-district as well as intra-district discrepancies are significant in respect of almost every sphere of human well-being. The analysis presented is in a highly compressed form and these discrepancies in spread are not examined in any detail.

There is a general point worth highlighting. Sri Lanka has been a market economy, both before and after the liberal reforms commencing from the 1970s. Yet market interventions by the government have always played a significant role in respect of IADGs. This meant that large volumes of resources, domestic and foreign, have been mobilized and utilized by the public sector to achieve the high levels of human development Sri Lanka now enjoys. Political attractiveness of "social welfare" projects has also led to significant duplication leading to waste of scarce resources. Projects leading to similar outcomes have been carried out by different agencies, governmental and non-governmental, to benefit the same social groups. Inter-agency co-operation to synchronize effort would enhance benefits derived from resources going for social development.

IV.1 Poverty

Sri Lanka is well on track to reach the target of reducing extreme poverty at national level by half by the year 2015. The more recent focus on the development of rural Sri Lanka has yielded desirable results. Districts which are dominantly rural have witnessed greater improvement in poverty conditions during 2002-07. Districts from the Southern Province have done extremely well. For instance Hambantota district which experienced a slight increase in poverty levels during 1995/96-2002 could eliminate most of its poverty during 2002-2006/07. In contrast, the Colombo district had lost its top position of lowest District-wise poverty incidence and moved down the rank. For all these results credit can be given to the rural development drive undertaken by the incumbent government. The available information also highlights the increase in poverty in the estate sector in general and the Nuwara Eliya district in particular during 2002-07.

The general approach to poverty reduction relies heavily on "free" supply of services and income transfers from the state to the households. This places a heavy burden on the government budget. Another challenge in this approach to poverty alleviation is the difficulty of proper targeting of relief payments and "free" services provided. The government is aware of the significance of promoting economic activities and productive employment among communities and regions in poverty in a sustainable poverty reduction program. In such programs, the required infrastructure is provided using public resources often in voluntary collaboration with beneficiary communities.

Livelihoods are promoted among poor communities in co-operation and participation with the people concerned. Such approaches to poverty alleviation need further strengthening.

IV.2 Employment

Issues of employment and unemployment in Sri Lanka have always been exceedingly sensitive from a political perspective, particularly because of heavy concentration of unemployment among the youth and the educated. Policy makers have therefore been very concerned about employment effects of principal policy actions. The first decade or so of the period of liberalization since 1977 began with a clear improvement in employment conditions but ended with a substantial worsening of the problem. After 1990 or so, the policy makers have been extremely careful of employment effects of policy action. This concern for employment effects is particularly strong today. The rate of unemployment remained at a single digit level since year 2000. It has gradually declined since 2005, with the latest available information for the 4th quarter of 2008 indicating a rate of unemployment of 5.2 per cent – a historical low for Sri Lanka.

This recorded decline in unemployment is indicative of human development. There are known lacunae in the definition of employment adopted in the relevant labour force surveys. Persons engaged in "some work for pay or profit or family gain during the reference week" are treated as "employed". A large proportion of those counted as employed on this basis are likely to have been engaged in work that is of poor quality in terms of remuneration and other conditions of work. About a quarter of the numbers employed in 2008 was in "elementary" occupations. These are likely to have been low quality occupations. A gradual improvement in the structure of available occupations in favour of better quality jobs would strengthen human development achievements.

IV.3 Education

Sri Lanka has achieved almost universal primary education with net enrollment ratio reaching 97.5 percent in 2006, for both males and females (in 1996 this figure was 95.7). If the present trend is maintained uninterrupted, it is possible to achieve universal primary education well before 2015. Sri Lanka had a more serious challenge in keeping the enrolled students in school although there has been a substantial improvement of conditions in this respect too. For instance only 68 percent of the enrolled students reached grade 5 in 1990. This has improved to almost 100 percent in 2006/07. Literacy rate among the 15-24 age group has stagnated around 95 percent since 2000. The rate in 2006 was 95.8, 94.8 and 96.6 percent respectively for total, male and female populations. The slightly higher rate for females is worth noting. Also to be noted is the substantially lower literacy rate in the estate sector. Further, this ratio has dropped from 87 percent in 2001 to 80 percent in 2006 for males in the estate sector.

Most MDG targets in the education field appear attainable, including the target to eliminate gender disparity in all levels of education. The challenges that Sri Lanka face—the high dropout rates at the Junior Secondary Level, and poor performance in GCE(O/L) and GCE(A/L) examinations—are mainly due to lack of investment in education facilities and inadequacy of capable and motivated teachers, especially in rural, plantation and formerly civil war affected areas.

Much can be done to improve quality of education while also adjusting it to evolving socio-economic needs through better use of available physical and human resources. Yet there are challenges beyond the control of the education sector. Acute poverty is still the main reason for non-participation of children at the primary stage. Children in such families are employed to supplement the family income. Low literacy levels of parents prevent them from understanding the value of sending children to school. Limitations of funds the government allocates for education prevent upgrading of classrooms and basic facilities and introduction of better teacher training systems.

IV.4 Health

On the health front under-five mortality rate had declined in 2005 to less than half of what it was in 1990. It is on track to go down by two thirds by 2015. Infant mortality rate has declined from 19.8 per 1000 live births in 1990 to 11.3 in 2003, placing Sri Lanka on track to achieve the target of 6.6 in 2015. The proportion of one year old children immunized against measles has reached 97 percent and therefore will reach the target well before the year 2015. Maternal mortality rate at 2 per 10,000 live births in 2003 has declined by over half since 1990, and is well on track to achieve reduction by three quarters by 2015. The proportion of births attended to by skilled health personnel has reached 97.6 per cent according to Demographic and Health Survey of 2006/07, and almost uniformly so across all sectors. Healthy practices of antenatal and postnatal care have become widespread in all segments of society. All the above health indicators are considered rather exceptional for a developing country with a GNP per capita of US$ 1,600.

A concerted and coordinated healthcare strategy implemented over a long period, supported by developments in other spheres, was necessary to attain the above successes in health related goals. In contrast, combating HIV/Aids in Sri Lanka has been relatively easy primarily due to its low prevalence and truncated nature of its spread in the country. Partly for this reason and partly for the sensitive nature of the subject in sample survey settings, data that are available on indicators of the incidence of HIV/Aids are limited to greater extent than in the case of most other human development indicators. Awareness of the disease among vulnerable segments of the society is considered satisfactory thanks to effective communication and high literacy conditions among the people. Reported data however, indicate an increasing trend in HIV infection, although the increase has been slow. Care on the part of authorities is needed to maintain the country's favourable position in terms of HIV spread as the

country is subject to certain important vulnerabilities in this regard [UNDP and NCED (2009a and 2009b)].

IV.5 Gender Equality and Empowerment of Women

Sri Lanka has already achieved the identified MDG targets in respect of the gender equality goal, except for the target involving the proportion of women in national parliament. The female to male ratio in education is already at 100 per cent or higher nationally – 99 per cent in primary education, 106 per cent in secondary and 187 per cent in tertiary. There is very little variation in these ratios regionally or in terms of the rural-urban-estate sector breakdown. The ratio of literate women to men in the 15-24 age category in 2006 was 101.8 per cent and the share of women in wage employment in the non-agricultural sector, 32.2 per cent. As against these ratios indicating high gender equality and high female participation in economic activity, the proportion of seats held by women in the national parliament (2004-7) however, remains insignificantly low at 6 per cent. Female representation in elected bodies at sub-national level (e.g. Provincial Councils) too is insignificant. Over the years there has not been any trend increase in these proportions. Female participation numbers, excluding the last, and certain other similar numbers (e.g. female presence in professional services) would indicate substantial gender equality achievement. It may be noted in passing, however, that scholars and social workers in this sphere are not always happy about these ratios as adequate measures of gender balance.

IV.6 Sustainable Development

The forest cover had dropped from 34 per cent in 1992 to 32 per cent in 2000 and 29.9 per cent in 2005. The ten year development plan (Department of National Planning, 2006) sets a target of 33 percent of land to be covered by forest by 2016 via the National Tree Planting Campaign. Yet deforestation still continues due largely to clearing of forests for agricultural purposes and for large scale irrigation and settlement projects. How these development activities could be carried out with adequate sustainability safeguards continues to be a challenge. The enforcement of existing regulations to minimize unauthorized felling of forests and mobilization of local communities in forestry development are difficult activities in policy implementation.

Nearly 85 percent of households in Sri Lanka in 2006 had sustainable access to safe drinking water, compared to 68 percent in 1990. This is indeed a significant achievement. This proportion is expected to reach 90 per cent in 2016. Safe drinking water here is defined to cover pipe borne water, water from tube wells and from "protected" water sources. Medical professionals seem to disagree that water from these sources is always "safe". Yet the increase in the percentage above shows a significant progress insofar as water quality remained relatively stable between the

two years cited. On the definitions used the MDG target of access to safe drinking water at national level is already achieved.

In 1990, only 69 percent of the households in Sri Lanka had access to improved sanitation. This ratio rose to 94 percent by 2006/07. The MDG target on sanitation is already achieved and if the current trend improvement continues in all sectors it would be possible to reach 100 percent sanitation level by the year 2015.

IV.7 Science and Technology for Development

Sri Lanka used mechanisms familiar elsewhere – education and training, setting up research and consultancy institutions with required funding, FDI promotion, facilitation of technology transfer etc. – to exploit science and technology (S&T) for development. The government attempt at dissemination of S&T in rural areas is worth special note. The *Nenasala* – "knowledge centres" – initiative of the Information and Communication Technology Agency (ICTA) has been described in a study prepared for the World Bank (Jensen, 2007: 5) as "... one of the largest and most sophisticated programmes for supporting public access to ICTs in the world". Special S&T dissemination centres – Vidatha Resource Centers (VRS) – disseminate S&T to distant rural areas. This programme envisages transferring S&T knowledge to rural population and thus to assist them in setting up productive self-employment and income enhancing activities. Research facilitated by the government on alternative energy sources may also be noted.

IV.8 Migration and Development

Migrant remittances have remained a major foreign exchange earner for Sri Lanka since the mid 1970s when migration for employment to Middle East expanded among selected categories of skilled and unskilled workers, most importantly among women for domestic work. Labour migration is being actively promoted even today as it fulfills four main roles of national significance: provision of jobs for domestic workers, generation of foreign exchange, stimulation of local demand and accumulation of investment funds.

Information about the total stock of Sri Lankan workers abroad is limited. In contrast, there is a data series about annual placements in overseas employment built up by the Bureau of Foreign Employment. Thus over 200,000 placements are recorded for every year since 2002. The number recorded for 2007 at 217,306 was about 3 per cent of labour force. A large number of families are involved in this labour migration phenomenon with a member or several of them either currently working abroad or having worked abroad in the recent past. Remittances from them have contributed significantly towards the easing of the country's external imbalance and the savings gap, in addition to enhancing family incomes.

IV.9 Social Integration and Vulnerable Groups

Of different vulnerable groups in society, the internally displaced persons (IDPs) are currently drawing extensive attention, both domestic and international. These are predominantly the conflict induced IDPs, with the largest proportion of them becoming internally displaced due to military operations in Northern Sri Lanka which eventually led to the defeat of the LTTE in May 2009. The work of relevant government agencies like the Ministries of Resettlement and Disaster Relief and Social Services and Social Welfare attend to IDP problems with relative speed. The relatively rapid Sri Lankan response to the tsunami disaster of December 2004 and to the IDP problems due to government military action against the LTTE in the Eastern Province in 2007-8 is indicative of the effectiveness of the institutional structures, both governmental and non-governmental, in situations of disaster.

Among issues of social integration the most challenging in the time to come would be those pertaining to relations between the ethnic Sinhalese and the ethnic Tamil communities. These are communities who have co-existed peacefully in Sri Lanka for centuries. Ethnic rivalries engendered by the divide and rule policies of the British colonial rule were allowed to grow further during various elected post-independence regimes. These became stronger as a result of the LTTE-led separatist armed conflict in the north and east of Sri Lanka from the 1980s. The LTTE's capacity to wage war on conventional lines has now been completely destroyed by the armed forces. Its terrorist capabilities too have been decimated. Given the nature of this conflict, particularly how the underlying issues were articulated and presented over the protracted period concerned, national/ social reconciliation within the multi-ethnic Sri Lankan society in the time to come will be an extremely challenging task. The manner in which post-war reconstruction has been undertaken initially in Eastern Province after that region was liberated from LTTE control and also in the Northern Province after it was liberated in mid-May 2009 makes one optimistic about the future (see IV.10 below also). The significant policy statements made by the President after the elimination of the separatist threat posed by the LTTE are indicative of the strongly reconciliatory approach of the government to nation-building.

IV.10 Democracy, Human Rights and Good Governance

Sri Lanka has been a practicing electoral democracy throughout its post-colonial period. Multi party democratic elections have been frequently held, sometimes nationally to elect the country's executive President or members of Parliament, and sometimes at sub-national level to elect members of Provincial Councils or local authorities. The people do get closely involved in elections and the voter turn out is usually in the range of 70-80 percent. Results announced after elections have always been accepted by all contestants. On many occasions regimes in power were changed through elections.

During the past years of violent conflict, the terrorist activities of the LTTE had denied the people of Northern and Eastern Provinces the freedom to exercise their democratic rights. However, following the clearing of the Eastern Province of LTTE activities in 2008, democratic political and electoral processes were restored in this region. Local Government Elections were held in the Batticaloa District, followed by Provincial Council Elections of May 2008. Through this process democratic electoral conditions were re-established. After elimination of LTTE control from the Northern Province, an accelerated process of long-term resettlement of affected civilians is being implemented. Re-introduction of electoral processes in this Province too is being planned. An environment that is conducive to promotion of human rights, including the right to vote and the right to elect their own representatives, is thus being established in these two conflict-affected regions.

Human rights are enshrined in the constitution and are justiciable, including the right to hold opinions of one's choice and to express them freely. The Constitution provides for direct access to the Supreme Court to seek redress for violation of fundamental rights, including the freedom of expression. Many whose rights are violated can be seen seeking remedial action in court. Some of these human rights cases generate extensive public interest. There is a vibrant press and freedom for the media to express opinions. There are several television and radio channels and many news papers and news magazines promoting the right of opinion and expression. The numerous political parties, activist groups and voluntary associations representing different interest groups exercise their rights of expression and of organization. Even under extraordinary conditions of emergency rule, there is extensive multiplicity of ideas finding expression in mass media. The people in the formerly conflict zone have been compelled to live for several decades with democratic rights substantially denied to them. The recent termination of armed conflict in these regions augurs well for restoration of democracy and human rights.

Conditions of governance in Sri Lanka show up many positive features – practice of electoral democracy, exercise of legislative and executive authority by the popularly elected, prevalence of the rule of law and all round respect for the judiciary. Political power has been used to promote the development of human well being, making Sri Lanka an "outlier" in international comparisons of living standards. Institutional mechanisms are in place to improve governance practices – a Parliamentary Ombudsman, a Public Services Commission, a Judicial Services Commission, a **Commission** to Investigate Allegations of **Bribery** or Corruption and so on. There are negative aspects, largely due to inadequate economic, social and political development. Two particularly important negative aspects of governance are the weak or underdeveloped capacity for problem solving and for conflict resolution and the widespread perception of a high degree of corruption at political and administrative levels of government. The institutional mechanisms in place to address these issues are gaining experience and there is continuing public pressure to address these issues.

V. Contributions from International Development Cooperation

It was around the mid-1960s when the very early institutional arrangements were set up to link Sri Lankan development efforts with ODA processes. Since then ODA flows have made a significant contribution to Sri Lankan development. The ODA flow increased in volume during the liberal policy regime. Its involvement was mostly in large and small infrastructure projects – e.g. the Mahaweli Project in the 1980s and numerous road construction and power projects in more recent times. In addition, ODA resources worked towards social development as well. The large number of integrated rural development projects operated at district level was funded by foreign aid. ODA has provided also a fair proportion of resources that went into health and education sectors. These ODA resources came from bilateral sources from the Development Assistance Committee (DAC) countries of the OECD, other friendly countries, and from multilateral sources. With Sri Lanka crossing the middle income country threshold in the late 1990s ODA flows gradually declined. For required foreign resources for developmental purposes, the government has turned in recent years to concessional loans from non-DAC countries and for commercial borrowing. During the earlier period, overall policy was often subject to conditionality of multilateral organizations and most ODA projects were donor driven. In the latter period, there has been no significant involvement of these multilateral organizations in development policy. There was also a decline in donor-driven ODA funded projects.

Responsibility for achieving IADGs rests with the government of Sri Lanka. Yet international development partnerships have been important in reaching these. Even a casual glance at the pattern of allocation of ODA resources, program-wise and project-wise, would indicate their contribution to IADG attainment process. The developing countries have entered into a commitment to pursue IADGs but there is little evidence that the donor community in fact uses these goals as a planning framework for allocating resources they set aside for development assistance among recipient countries.

Part B: Health Sector Achievements and Challenges

VI. Health Sector: An Overview

Significant advances were made in the delivery of health services to people in Sri Lanka during the period since the early 1930s, part of it under colonial rule. Institutional foundations for the post-1931 expansion of health services were already partially laid by the colonial regime. Since 1931 there was gradual expansion in health services due to many socio-economic and electoral-political pressures (Samarasighe, 1998: 342-3). Human and physical facilities in the public health sector have expanded over time through resources pumped in by the state. The sector is able to treat over 4.6 million in-patients and 43 million out-patients (the numbers refer to the actual in 2007). As the return to the consistent flow of public funds, both recurrent and capital,

into the health sector over the years people's health conditions have improved significantly. An important factor here has been the growing awareness of the people about, and their positive attitudes toward good health. Healthcare authorities also accord great significance to individual and community empowerment in regard to the improvement of health seeking behaviour. The high literacy conditions in the society have indeed helped improve people's participation in maintaining conditions conducive to better health.

Behind low income Sri Lanka's "success story" (de Silva, 2004: 426) of health achievements stand a series of socio-economic and political factors. Among these the contribution of the healthcare sector has no doubt been substantial. Most "health care sector" discussions are likely, advertently or inadvertently, to refer exclusively to institutions and practitioners of allopathic medicine. It is nothing but fair, however, to note the contribution of the ayurvedic and other traditional systems of healthcare to improve people's health conditions.

There are two salient features of the system of management of Sri Lanka's public sector health care system: (i) the provision of health care free of charge[3] and (ii) "provision of services close to the client" (*ibid.*). Because of electoral pressures, public sector healthcare institutions continue with the system of free health services. The private sector has, however, been allowed "to provide an alternative treatment source that would help reduce government health care costs" (de Silva, 2004; see also MoH, 2000). Public sector healthcare authorities are engaged in promotive, preventive, curative and rehabilitative healthcare services (www.health.gov.lk).

There is policy commitment to promote the indigenous systems of medicine, the ayurvedic tradition in particular, in addition to allopathic medicine. Public investment on these traditional systems has gradually been raised in more recent times. It is not surprising that, in a context where patients view ayurvedic treatment to be chemically less invasive and more responsive to some of their health needs, the public sector supports a system of pluralistic care (www.ayurveda.gov.lk). Due to space limitations, however, this paper does not cover health policy matters involving traditional systems of medicine.

VII. Achievements

Sri Lanka's achievements in social indicators that are subject to public sector healthcare policy and practice are truly impressive when compared with other developing countries of similar standing and also with Sri Lanka's own conditions in relatively recent past, say in the mid-twentieth century. There is no space in this study

[3] Free universal coverage was perhaps needed at early times when the provision of basic minimum healthcare was itself a challenge. Given the demographic, social and epidemiological changes noted in section VIII below, careful rethinking is needed about the types of services included in universal free coverage.

for a detailed examination of all these achievements. The brief statement below ought to be read with the analysis in section IV.4 above.

The healthcare sector contribution to human development came from spheres of preventive and curative care. The impressive achievements in terms of health indicators like rates of overall, infant, maternal and child mortality, life expectancy and so on are to a large extent the result of good work in the sphere of preventive care, supported by the process of general socio-economic development. The contribution of governmental action in the public health sphere to reduce the incidence of communicable and parasitic high-killer diseases needs special mention here. Sri Lanka's immunization program has been the most successful such program in the South Asian region, covering babies in all sectors – rural, urban and plantation sectors. Sri Lanka was able to effectively control or eliminate all vaccine preventable diseases through superior levels of sustained infant immunization coverage.

On WHO criteria, Sri Lanka has already eradicated the debilitating diseases like filariasis and leprosy – a feat which many other countries in the developing world have not yet been able to achieve. Through its impressive immunization program, Sri Lanka has eradicated polio and measles. Iodine deficiency disorders have been eliminated. The health authorities in Sri Lanka are confident of being able to achieve complete malaria eradication by 2015. HIV/Aids which has taken epidemic proportions elsewhere is of very limited prevalence in Sri Lanka. The high standards achieved in water supply and sanitation conditions have helped in the achievement of high levels of public health. In the recent past, the emphasis in the preventive healthcare program has shifted to a set of communicable diseases which have acquired significance during the last few years – dengue, chikungunya and rabies, together with malaria which has re-emerged as a major health challenge.

In regard to improvement of conditions of curative care within public sector medical institutions, a series of reforms have been undertaken and higher investments made for improvement of available facilities. In order to address issues of equity in the regional distribution of healthcare facilities, a policy of selecting and upgrading at least one hospital per district has been initiated. An underlying objective of this policy has been to modernize and improve the quality of healthcare facilities that are available in under-served areas. Funding has been made available to construct staff quarters for medical officers in difficult areas to attract and retain their services in such areas.

In addition, the government has taken action to improve available medical technology in major hospitals in the country through a program of investment in public sector medical institutions. A centre of excellence in nephrology was set up in Colombo with facilities for diagnosis, dialysis and kidney transplant surgery. A few other notable investments in the recent past included the Korea-Sri Lanka Friendship hospital in Matara, Neuro Trauma Unit in the National Hospital in Colombo, improvement of cardiology, oncology and maternity wards of the Kurunegala General Hospital,

construction of a surgical treatment complex in and provision of modern medical equipment for the Kandy General Hospital and similar improvements made to the Anuradhapura General Hospital. Besides such major hospital development projects, a significant share of capital investment has also been channeled for the rehabilitation of, and the purchase and installation of needed equipment in hospitals. Foreign assistance has been mobilized for healthcare sector investments, although these investments were financed mostly from domestic funds. Together with increasing capital investments, there has also been expansion of recurrent expenditure to increase employment numbers and medical supplies, thus helping in the process of improvement in the quality of services provided in government medical institutions. Particularly noteworthy is the increase in the recruitment of medical and paramedical officers and support staff for the service in institutions located in distant rural areas.

Clearly there is more to be achieved to provide inclusive conditions of healthy life to all social groups and regional segments of population. In this, many institutions other than the healthcare related ones have to play and are playing a significant role in collaboration with healthcare institutions – municipalities and other local authorities, and institutions dealing with matters pertaining to environmental issues, housing, water supply and sanitation, education and so on. The contribution of the healthcare system in the promotion of healthy life in Sri Lanka, among that of all these other institutions, has been vital and dominant. Good health so promoted has been in the backdrop of the country's impressive human development achievements. These achievements no doubt provide reasons for self-congratulation. Positive lessons Sri Lanka's healthcare experience could bring out for the benefit of the rest of the world are immense.

VIII. Health Challenges

In the midst of commendable achievements, the health care system of Sri Lanka currently operates under many challenges and stresses. These challenges are mostly systemic and institutional, associated with the overall country situation in terms of macro-economic, developmental, historical, social, political and legal considerations. Problems of child nutrition and development persist (Aturupana *et al.* 2008) in spite of very low infant and child mortality rates. Adequate resolution of problems of low birth weight babies and low nutritional status of children and mothers require the society moving out of general conditions of underdevelopment. General socio-economic development itself would improve environmental and hygienic conditions of living in many poor communities. Without such generalized conditions of human development, the prospect of a longer life, to many, may turn out to be more a punishment than a reward.

Remaining public health issues need action on an extremely wide canvass to resolve. Action from pre-school and school levels is needed to train people to value living in healthy surroundings. The improvement of housing, sanitation and water supply

conditions and the management of solid waste disposal require action from individuals and communities as well as from responsible authorities and officials at various levels. Effective laws to regulate manufacture, importation and distribution of food are needed and also those governing occupational health. Also needed is legislative and executive action to regulate the use of pesticides. In most fields affecting public health, Sri Lanka has the necessary legislation. Problems encountered are in the sphere of monitoring and enforcement. This has become increasingly difficult.

The following sub-sections present a brief review of some major challenges facing the healthcare sector. The analysis is based on available studies and dialogue with stakeholders.

VIII.1 Epidemiological Transition Challenges

Population dynamics in Sri Lanka have been such that the country is in a demographic transition in the sense primarily of a process of population ageing. This is leading to an epidemiological transition – shifting burden of ill health from communicable and parasitic (e.g. malaria, tuberculosis, cholera, typhoid, diarrheal diseases, filariasis etc.) to non-communicable diseases (e.g. diabetes, hypertension, ischemic heart disease etc.). The disease burden due to degenerative diseases of adults has increased significantly[4]. Together with the tendencies making Sri Lanka's disease pattern approximate that of a developed country, disconcerting levels of morbidity arising from infectious and parasitic diseases persist. This has been described as "a double burden of disease" (Samarasinghe, 1998: 349).

Increased coverage of the government network of health care facilities and increased access to care played a significant role in achieving good health care indicators at significantly low cost. Healthcare facilities of a different nature are required with different patterns of availability and access to address the new challenge of non communicable diseases. Up to now Sri Lanka has done well to prevent individuals from falling into catastrophic health expenditure problems driving them to poverty. The situation can however, change if the issue of non communicable diseases is not addressed in a timely manner.

VIII.2 Financial Resource Constraints

Health financing in Sri Lanka comes from the public[5] (including donor assistance) and the private sectors[6]. The proportionate distribution of total health expenditure between

[4] There are reasons not directly related to demographic transition causing changes in disease patterns. With changes in people's life styles, for example, injuries have become a very prominent cause of hospitalization since 1995. In addition, there is also a rise in mental disorders in recent times.

[5] This includes expenditures incurred by the ministries of health under the Central and Provincial governments, other ministries and local government authorities.

[6] This includes mainly households. Other components include employers, non-profit organizations and private health insurance.

these has remained relatively stable over the recent past. The health authorities estimate that during the period 2004-06 the public sector ratio ranged between 46 and 49 percent and that for the private sector correspondingly between 51 and 54 percent. Funds for the overwhelming bulk of public health expenditure are obtained from tax revenues.

Government health expenditure as a ratio of total government expenditure was around 5 percent during 2004-5 and had risen to 7.6 percent in 2006. As a ratio of GDP it declined in the 1990s (MoH 2000: 2-1) but picked up in the following decade. This ratio remained around 2 percent since 2004, also showing a mild tendency to rise after this year. The government has remained committed to the principle of free health services in the public sector. Average health care costs have been constantly going up. The epidemiological transition as a factor behind rising health costs has already been noted. Having already reduced mortality rates to a substantial extent, further improvements in mortality and morbidity conditions of people have turned out to be highly resource intensive. The required funds to maintain and improve existing facilities and to construct new ones within the public sector had to be mobilized predominantly through taxation, as the contribution from foreign aid has traditionally been marginal. Adequate funding of the public sector health services has thus become a challenging task over the years. Difficulties due to fund shortages have been compounded by elements of inefficiency and wastage in governmental institutions. While attempting to increase resources earmarked for the public sector healthcare services, a steady growth of the private healthcare sector was allowed over the years. The focus of the government has been to making its own health facilities serve low and middle income groups while promoting the richer classes to required services from the private sector.

Many committees have examined and recommended supplementary sources of finance. Lethargic has however, been the administrative and political action to implement the proposals worked out by these committees. In the Sri Lankan electoral democracy, with the great bulk of the populace at low income levels and with no other alternative system of social protection, free health services are likely to be maintained in public health institutions for a long time to come. Achieving a relatively high level of health for the people at low expenditure levels is Sri Lanka's admirable accomplishment. In spite of financial constraints, however, many of the state sector health care institutions have been able, over the years, to improve their service quality.

VIII.3 Problems Related to Devolution

The distribution of available public financial resources between the centre and the provinces in the prevailing system of devolved governance is of particular significance in determining the equity in the distribution of healthcare facilities. Health care provision, excluding those components provided directly by the centre, is a devolved subject. The healthcare related responsibilities reserved for central government include

national health policy matters and the management of teaching hospitals and hospitals established for special purposes. The Provincial Council system for devolved governance has proved to be rather stressful at both political and bureaucratic levels, failing to produce the potential benefits of a decentralized system of management. It has failed to promote high quality demand-driven service delivery to local communities (Mowlana *et al.* 2005; Gunawardena *et al.* 2008). Provincial Council finances are heavily dependent on funds distributed to them by the Central Government and the underlying system of distribution of financial resources has not been conducive to any managerial innovation.

VIII.4 Human Resource Constraints

The total numbers of health personnel – medical practitioners, nurses, pharmacists, lab technicians, radiographers, physiotherapists etc – available in the system are generally adequate in the areas like the Western Province but not so in the remote Provinces. Particularly acute are the shortages in trained health personnel in the two conflict-affected Provinces – Northern and Eastern. Varied have been the types and degrees of imbalances in the available workforce – numerical imbalances, imbalances in terms of qualifications, distributional imbalances (Samarasinghe, 1998: 358). Qualified medical officers are now appointed for most of even the small healthcare institutions are equipped with. Supervision, however, is not strong enough to ensure that their services are available for these small units on a regular basis (de Silva, 2004). The process of recruitment and training of professional health workers below the category of medical practitioner has been accelerated to address the issue of inadequacy in their numbers within the system.

VIII.5 Administrative/Managerial Issues

Issues discussed here emanate largely from certain contradictions that are inherent in the co-existence of public - private sectors in healthcare provision without clear boundary demarcation between the two. "Off-hour private practice" or the so called "channeling" practice allowed to specialist medical practitioners in public sector has perhaps resolved the retention problem to a substantial extent but has opened up room for other problems. The point has been made that this has opened up room for a subsidization of private medical care (de Silva, 2004). Another activity in which both sectors operate is importation of pharmaceutical products and other healthcare related consumables. Private sector pharmacies are in operation under relaxed regulations and many private hospitals have come up, some very big and other not so, under government approval. Licensed private diagnostic facilities are widely available. Thus two systems function simultaneously within the health care sector - one with a profit motive and the other with a service motive. Preferential access to and utilization of government facilities by the profit motivated private sector has created many problems. An unofficial system of fee levying is in operation and there is pilferage of drugs and consumables from the state sector (*ibid.*: 362).

Due to resource shortages in the public health care sector, rationing, overt or covert, has become necessary in all spheres of healthcare activity. As medicines are in short supply what is available has to go around large numbers who are being treated. Patients are often advised to purchase required products for medical care from the market – drugs, devices, lab investigations etc. These are usually part of out-of-pocket expenses incurred by patients for healthcare. This means an indirect introduction of a user fee, although the fee that is "charged" does not come into the public healthcare system.

Overcrowding of both in-patient and out-patient facilities is a reflection of both the serious resource shortage and certain systemic weaknesses. Inadequacies in physical space as well as personnel in health care facilities are a significant part of the overcrowding phenomenon. Direct consultation of specialist medical practitioners, described as "self-referral", has developed into a systemic aspect of health care behavior over the recent past, both a sign of shortcomings in feeder facilities and patients' concern to obtain best medical attention as early as possible. The patients are in a position to do this as information about specialist doctors is widely disseminated. Transport facilities are available at subsidized cost for patients to move from even distant places to wherever channeled medical consultants are. Whether lower end facilities would be improved to introduce enforced referral systems or these lower end facilities would be closed down remains a politico-administrative challenge.

The Sri Lankan health care system is a complex, huge and quite centralized machinery, together with, as noted earlier, some moderating elements of devolution through a sub-national tier of decision making. While there are individual elements in this structure which are of a high degree of management efficiency and effectiveness, the system as a whole is shown to incorporate a significant extent of inefficiency and ineffectiveness. The central government Ministry of Health is aware of the problems and is working towards improving work performance through contracting out management improvement consultancies, internal training sessions and seminars and changes in management systems.

There is also the essential need to effectively regulate the private sector in healthcare provision. This sector, as it exists, is an extremely heterogeneous system. Very little is known about its composition in terms of services offered and resources available, and the regional distribution of facilities it offers. The two sectors are mutually linked, often making the private sector in many ways dependent on the public sector. Effective systems of regulation are required firstly, to ensure an improved information flow about entities in the private sector and secondly, to improve the standards of healthcare of these entities and to make these duly responsible and accountable. This has indeed become a major concern.

VIII.6 Equity in Health Care Provision

Equity in essence implies fairness. An equitable health care system would provide satisfactory health care access to the vulnerable and the needy in society as well as to the rich and the affluent; to people living in remote, rural and underdeveloped areas as well as those living in metropolitan, urban and other developed areas. The pattern of distribution of health outcomes among different social categories shows that the Sri Lankan system has yet to reach acceptable equity level. Significantly lower than average health outcomes are known to be observed in pockets of the estate sector. Access to health care services is very poor in conflict affected regions of the Northern and Eastern Provinces. Several Divisional Secretary Divisions are identified as poor health care access areas.

The authorities are aware of these imbalances. The health Master Plan discusses the subject and remedial measures are proposed. The country's overall planning authorities consider minimization of regional imbalances in healthcare delivery, through improved access to quality services, as the main guiding principle in determining allocation of capital investment in the health sector. Many special health care (*Suwa Udana*) programs are regularly conducted in remote areas benefiting many underprivileged communities. Some health institutions providing access to estate sector people have been upgraded. Reconstruction of health facilities and the installation of effective healthcare distribution mechanisms in the conflict affected Northern and Eastern Provinces are currently priority policy issues.

IX. Concluding Comment

Sri Lanka has been able to pursue a policy framework that could perhaps be described as unique in the Third World. Through these policies Sri Lanka could achieve desirable human development outcomes over a long period of time. This policy framework has been guided by a set of higher level multiple goals – economic growth, redistributive justice, alleviation of absolute poverty, employment promotion, balanced regional development and environmental sustainability. The implementation of this policy framework has been extremely difficult as it constantly required sorting out difficult and complex trade-offs, contradictions and challenges, taxing the capability and innovativeness of policy makers and implementers at both political and administrative levels.

Sri Lanka has already attained or on track to attain the MDGs related to education and health - universal primary enrollment and completion, gender parity in primary and secondary school enrollment, low infant and under-five mortality rates. Economic growth has remained over 5 percent since 2002 and conventional open armed conflict in the north and the east has been concluded with the security forces emerging victorious. Several measures are being taken since 2005 to distribute the benefits of growth more equitably. Poverty decline process has therefore gained momentum. Even

in areas where Sri Lanka's performance has generally been impressive, however, there is evidence of significant regional disparities. The indicators shows that while the progressing (urban) regions in the country could achieve the goals earlier than 2015, geographically isolated regions with low accessibility and inadequate infrastructure facilities are still lagging behind.

There is much that the government has done and can do in future to progress towards IADGs. However the significant role played by donors and international funding agencies in achieving these cannot be neglected. In this light it may be important to factor in the current global financial climate and evaluate how it could potentially retard Sri Lanka's bid to achieve IADGs. Another important factor as far as the goals and the indicators go is the impact of the possibility of reliable and up-to-date statistics pertaining to Northern and Eastern Provinces being available in the future. There has been a clear slide back of these Provinces in terms of human development achievements there. Accelerated programs of human development are being implemented by the government. The target is not only to bring human development levels in these regions at par with other regions, but also to win hearts and minds of the people there in general and those belonging to Tamil and Muslim minorities in these provinces.

Part B of this study has examined policies achievements and challenges of a major social sector having a significant impact on IADG attainment, namely the healthcare sector. This sector study is extremely instructive about how the government of a country could help achieve valuable social goals through systematic intervention, in spite of the levels of economic attainment being not very helpful in the process. Sri Lanka has shown the world how a developing country could attain high levels of healthcare goals, even in the absence of comprehensive health insurance schemes, by setting aside a small share of government tax revenues for public healthcare expenditures. What the rest of the world can learn from Sri Lankan healthcare sector experience is immense.

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